



System: An Introduction to Ambulatory Payment Classifications (APCs) and Ambulatory Patient Groups (APGs)



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History of the PPS

- 1983: Inpatient PPS implemented
- 1986: Congress mandates development of outpatient PPS in OBRA 1986
- 1988: The Health Care Financing Administration (HCFA) awards 3M a grant to develop an outpatient classification system.
- 1990: 3M submits the final report on APGs to Congress
- 1995: APG version 2.0 was released by 3M
- 1997: Outpatient PPS was signed into law
- June 12, 1998: PPS regulations for freestanding ASCs were published
- September 8, 1998: Proposed PPS regulations for hospital outpatient services were published, indicating the use of APCs, a grouper modeled after 3M's APGs.
- June 30, 1999: Extended comment period deadline
- January 1, 2000: The original start date for outpatient PPS implementation
- July 1, 2000: The proposed start date for PPS implementation



Facility Impact

- ☞ The PPS is based upon ICD and CPT coding (diagnostic and procedural); **therefore services and treatment actually performed on a patient by a provider, dictate the billing and reimbursement structure for the facility!!**
- ☐ Patient care decisions made by providers will have a direct affect upon facility costs and reimbursement!!
- ☐ Proper documentation in the medical record is critical for reimbursement and compliance purposes. If information is not present in the medical record, theoretically, it does not exist!!

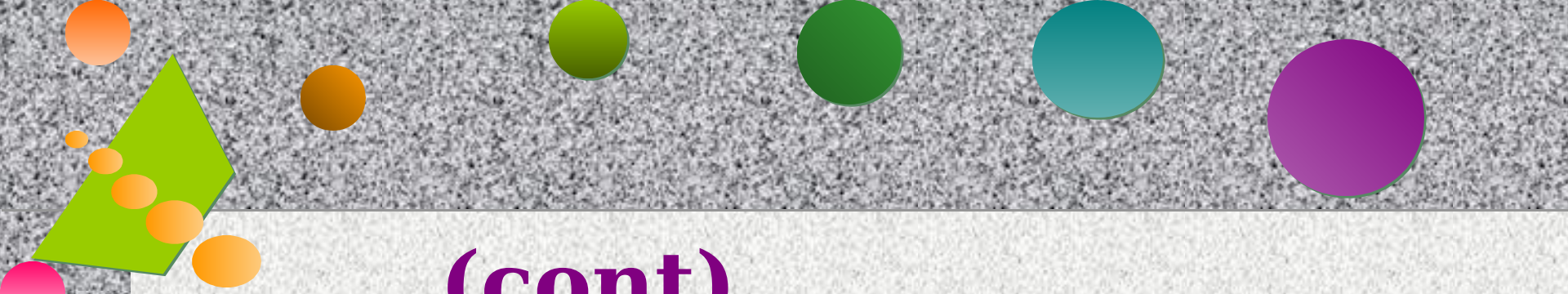
APGs vs. APCs

APGs

- 👤 A patient classification system designed to predict resource consumption during an ambulatory encounter (visit)
- ▢ Visit/procedure is based upon outpatient PPS
- ▢ 46 Categories, but 290 total APGs
- ▢ Assignment of APGs is based upon CPT, ICD-9, and HCPCS
- ▢ Multiple APGs can be assigned for one visit

APCs

- 👤 A patient classification system designed to predict resource consumption during an ambulatory encounter (visit)
- ▢ Visit/procedure is based upon the outpatient PPS
- ▢ There are 347 APCs
- ▢ Assignment of APCs is based upon CPT, ICD-9, and HCPCS
- ▢ Multiple APCs can be assigned for one visit



(cont)

APGs

🐼 Categorized as follows:

- Significant Procedures (Surgical and Non-Surgical)
- Medical Visits (Clinic and Emergency)
- Ancillary Services

□ 3M's data sample consisted of claims paid in 1992

APCs

🐼 Categorized as follows:

- Surgical Groups
- Other Non-Surgical Procedures
- Medical Visit Groups
- Ancillary Services/Other

□ HCFA's data sample consisted of 1996 outpatient claims and 1994 ASC survey costs and charges



APGs vs APCs (cont)

🐸 APGs and APCs affect:

- Hospital Outpatient Departments
- Free Standing Ambulatory Surgery Centers
- Community Mental Health Centers

🐸 APGs and APCs do not affect:

- Physicians
- Nursing Home Services
- Home Health

APGs vs. APCs (cont)

APGs

🐸 APGs do not affect payment for:

- Ambulance Services
- Physician Services

▢ APG Components:

- Window of Service (72 hr rule)
- Significant Procedure Consolidation
- Ancillary Packaging
 - Radiology
 - Lab
 - Pharmacy
 - Medical Supplies
 - Observation
 - OR/Anesthesia/Recovery Room

APCs

🐸 APCs do not affect payment for:

- Ambulance Services
- Physician Services
- Dialysis
- PT, OT, and Speech Therapy

▢ APC Components:

- Minimal Ancillary Packaging
 - Pharmacy
 - Medical Supplies
 - Observation
 - OR/ Anesthesia/Recovery Room



APCs' Payment Characteristics

- The basic unit of payment for an outpatient service is an encounter. An encounter is the occurrence of a patient coming to the provider facility, undergoing a procedure, medical evaluation, or ancillary service in an ambulatory setting.
- Similar to the current DRG system, the prospective price for each type of outpatient visit will include all associated routine services. **This provides financial incentives for hospitals to control the number of services associated with a visit.**
- Different from the DRG system, however, APCs allow patients to be assigned to more than one group for each service provided during a visit. **To control costs, the PPS will not reimburse hospitals for every service provided.**
- Multiple procedures performed during a single encounter will be paid at rates less than those if the same procedures were performed during multiple encounters. **The new PPS offers a disincentive for hospitals to perform multiple procedures during a single encounter.**



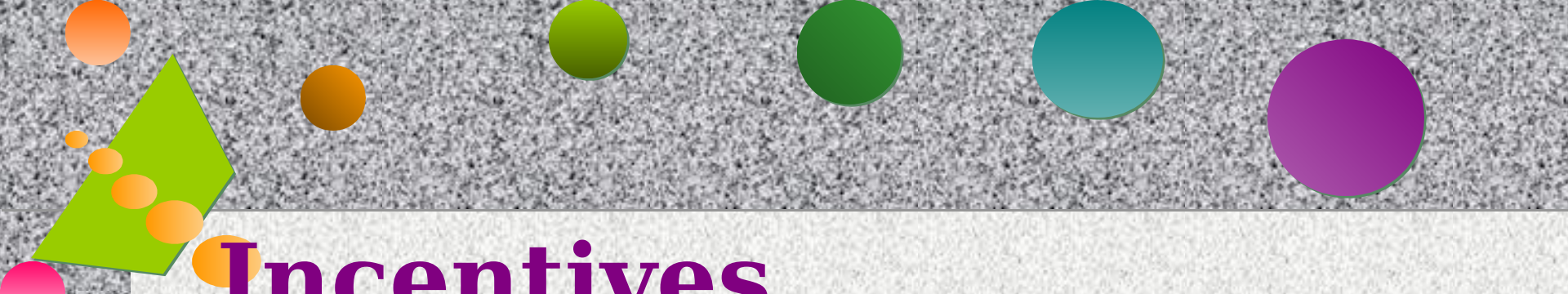
Implications for Outpatient PPS

- Greater financial risk
- Greater financial pressure
- Greater financial uncertainty
- The possibility of increasing claim denials and lost revenue.
- Multiple APCs make management reporting difficult.
- APCs will force facilities to evaluate outpatient services on a product-line basis, which is contrary to managing on a departmental basis.



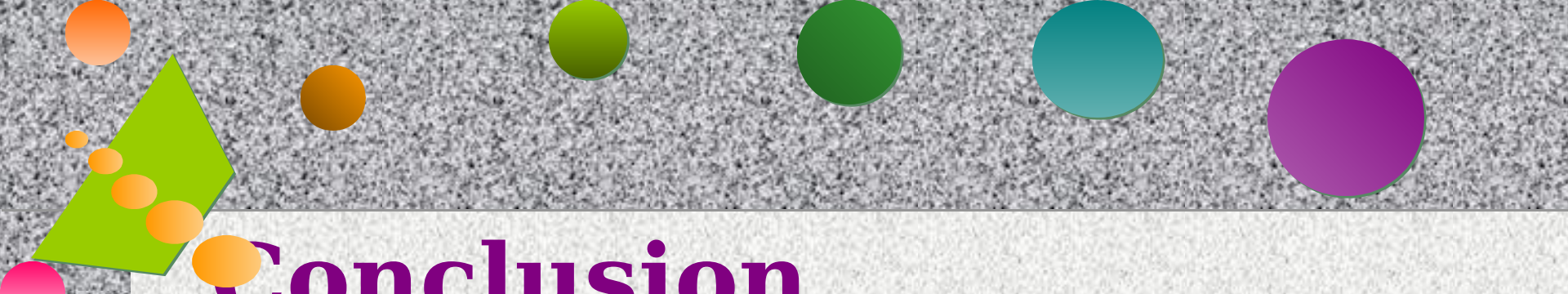
Documentation/Medical Records

- Diagnosis Codes on UB-92s are attestations that services claimed for payment are:
 - medically necessary
 - ordered by a physician
 - rendered as claimed
- Physician orders must be readily available in medical records as maintained by the facility.
- Whenever documentation is insufficient, there is no basis for a claim.
- Under APCs, coding for claims will require accurate documentation.



Incentives

- The PPS will likely provide an effective tool for managing facilities, controlling costs, and augmenting profitability.
- The PPS will provide a more effective and efficient means of collecting data and improving data quality.
- The collected data will enhance the ability to evaluate outpatient treatment and compare disease management trends.



Conclusion

🐸 Advanced preparation is the key to success.

- Identify financial risks
- Analyze billing processes
- Review Charge Masters
- Improve coding quality and accuracy
- Educate providers, clinical staff, administrative staff, medical records, coders and billers
- Modify computer systems and software



For more info...

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